Domestic Partner Dissolution

Employee Name_____ Social Security #_____

Employing Agency/Branch_____ Employee ID#_____

This form must be attached to a State of Montana Employee Group Benefits Plan Enrollment/Change Form and is to be used to remove an enrolled Domestic Partner from insurance coverage. The coverage end date is the first day of the month following receipt of the form in the Benefits Bureau.

Partner's Name _____ Partner's Social Security # _____

Dependent's Name(s) _____; _____; _____

Notification of Change in or Termination of Relationship

We, the undersigned, attest that our domestic partner relationship no longer exists.

_____

Employee Signature Date

_____

Partner Signature Date

_____

NOTARY PUBLIC

SEAL

_____

Date Commission Expires

Note: Premiums for coverage of domestic partners and associated dependents of the domestic partner will continue to be charged to the employee or retiree (or automatically deducted from the employee's paycheck) until the Domestic Partner Dissolution form and State of Montana Employee Group Benefits Plan Enrollment/Change Form are completed and submitted to the Benefits Bureau.